PATIENT SAFETY
FEEDBACK
Patient Safety Reporting System
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the psrs Annual Awards

In this *FEEDBACK* issue, report excerpts were selected as "best" examples among recent incidents reported to PSRS. They document the value of "great catches" that benefited VA patients.

And the Winners are . . .

Best Solo Performance

The outstanding performance of this PSRS reporter led to the correction of an equipment problem in the anesthesia department. During a routine preventative maintenance inspection, the technician found that some infusor pumps used in the OR could deliver an incorrect dose of anesthetic:

- Baxter AS40 can use syringes from three manufacturers
- Baxter Model PCAII OR Baxter/Bard/Harvard Model 150XL can use syringes from two manufacturers (but all three will fit!)

Tests were conducted at the facility and found that if an incorrect syringe size was used with a smart label in certain pumps, an overdose of as much as 22% or an underdose of 48% could be delivered. The biomedical technician stated that the following actions were taken locally:

■ *Action: (1) Anesthesiology service was advised to order, stock and use the correct brand(s) of disposable syringe and insure the pump's syringe selector switch identifies the brand prior to pt use. Any brand substitution must first receive hospital standardization and utilization approval and pass all performance testing... The hospital's inventory of infusor pumps has been removed from service until further notice. (2) Once the correct brand is in stock, both techs were advised to use only 20 cc and 60 cc syringes with the infusor pump and to match the syringe size to the attached smart label.*

This biomedical technician was concerned that similar safety issues may be present in other facilities so decided to share with PSRS!

Most Dramatic "Supporting" Role

A nurse observed a patient with an oxygen cylinder "not properly supported" leaving the VA grounds in a private car. The reporter described the safety hazard observed:

■ *Patient had tank* [cylinder] *between their legs. Tank and handle were at face level... If air bag were to deploy, patient would have O2 tank and handle of carrier tear their face up. The O2 tank can be a lethal weapon in any vehicle if there were to be an accident.*

The reporter was not aware of whether Respiratory Therapy had a formal educational handout or policy for patients related to O2 transport, but added:

■ *Respiratory therapy should instruct patient to seat-belt O2 tank upright in back seat with seat belt. There should be enough O2 tubing to reach* [the front seat].

Best Detection of a Documentary Feature

An ICU Charge RN detected the possibility of deleted medication orders in CPRS (POE) that are written in the evaluation unit (ER) for patients whose status changes from Outpatient to Inpatient status (ICU):

■ *Pt admitted from evaluation. Pt arrived with pantoprazole drip infusing at* [a standard rate]... *Upon admission, order disappeared from CPRS... This is only one of many instances of this problem. There have been instances of beta blockers and calcium channel blockers being ordered, prepared, and given, then pt admitted - order disappears. Next come new orders because no one can see what was given before.*

FEEDBACK shares excerpts of reports sent by VA personnel to PSRS. Actual quotes appear in italics. In May 2000, NASA and the VA initiated the PSRS, a voluntary, confidential, and non-punitive reporting system. PSRS encourages VA personnel to describe safety issues from their firsthand experience and to contribute their information to PSRS.

In the callback conversation, the RN stated the situation was recognized and prevented a patient from receiving a second dose of the same drug. The reporter recommends a local "work-around" process whereby all pts coming to the ER could be admitted immediately as an inpatient, and then either transferred to an inpatient treatment area or discharged. This method would allow all inpatient staff to read medication orders, etc.

Most Interesting Visual Effects

An RN reported a situation where pharmacy is placing "beyond use date" expiration labels over the manufacturer label on multidose (multi-use) vials:

- *Labels on medication vials – (multidose) covered the dosage. Example: Heparin 1:1000 units/ml – covered by label which expires in one month. Wrong dosage can be given when pulling label off to read dosage – pull off manufacturer label.*

Reporter stated that when removing the local expiration label, this often removes all or part of the original label that displays identity and strength. Although the reporter has spoken with the pharmacy (locally) about label placement, this RN wanted to share this possible system issue with others.

Meet a Leading Lady

Eileen Freeman (stagename: "Charli"), RN, brought over 30 years of acute nursing experience when she joined the PSRS medical safety analyst team in October 2001.

Prior to joining our team, Charli worked at Stanford University Hospital, where she participated in the care of high risk patients, critical care transport, medical research data collection, and unit cost containment. At PSRS, Charli

thoroughly enjoys meeting and talking with frontline staff through PSRS outreach visits to VA facilities. She also enjoys making callbacks to PSRS reporters and reflects: "It is always an eye-opening, empathetic experience to talk with reporters and learn 'the rest of the story.'"

Charli lives with her husband (of 30 years!) and her son in the California Sierra Mountains, where she enjoys a slower, simpler lifestyle and spectacular natural surroundings.

Got a Fix? Tell PSRS About it!

Fixes to problems often involve creative solutions and out-of-the-box thinking. If you or your facility have come up with fixes for problems, you can tell PSRS about them! We would like to share your ideas in an upcoming issue, so that all our readers can benefit from your creativity.

PSRS report forms and past issues of *FEEDBACK* are available on the VA intranet as well as the PSRS website.

You may subscribe to *FEEDBACK* at no cost by going to our website and clicking "Contact Us" or by mailing your request to:

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